Blue Shield of California
Life & Health Insurance Company
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Blue Shield of California Foundation
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HEALTH STATEMENT

(Applicable To All 5-14 Enrolling Employees and Non-Guaranteed Issue Groups Only)

If you would like to keep this statement confidential, please submit it in a sealed envelope along with your completed application.

Please complete the following health questionnaire. Your answers to the questions below do not affect your eligibility for coverage and will not be used as a basis of excluding coverage for any medical condition, with the exception of a pre-existing condition if applicable to the terms of your group health plan.

(Please print)

Employee Name	**Social Security #**	**Height**	**Weight**
Dependent Name	**Social Security #**	**Height**	**Weight**
Dependent Name	**Social Security #**	**Height**	**Weight**
Dependent Name	**Social Security #**	**Height**	**Weight**

Please answer YES or NO to each of the following questions for yourself and each of your dependents. (If you answer YES to any of the questions below, please explain referencing the Q# on the back of this form).

1. Been admitted to a hospital or had surgery in the past five (5) years? ☐ **Yes (explain below)** ☐ **No**
2. Within the past two years, have you, or has any dependent you are enrolling, been disabled and/or incurred medical costs exceeding $5,000.00? ☐ **Yes (explain below)** ☐ **No**
3. Been told that it may be necessary for you to be admitted to the hospital or have surgery in the future? ☐ **Yes (explain below)** ☐ **No**

Been diagnosed with, treated for or had treatment for any of the following: (If Yes, explain below)

	YES	NO
4. Heart or artery disease including heart attack, stroke, aneurysm, arteriosclerosis, chest pain, rheumatic fever or heart murmur?	☐	☐
5. Hypertension?	☐	☐
6. Cancer, tumor or other malignancy?	☐	☐
7. Diseases of the kidney, liver, gall bladder, pancreas or male/female organs including venereal disease?	☐	☐
8. Arthritis, back pain, rheumatic fever or musculoskeletal/joint problems?	☐	☐
9. AIDS, AIDS-related complex or other immune deficiency disorders (except HIV infection), infections or chronic infection problems?	☐	☐
10. Alcohol or substance abuse, mental/nervous disorders?	☐	☐
11. Ulcer, colitis, difficulty swallowing, stomach problems, hernia or rectal problems?	☐	☐
12. Diabetes, cystic fibrosis, albumin or sugar in the urine or other endocrine problems?	☐	☐
13. Asthma, emphysema, tuberculosis, pleurisy or other diseases of the lungs?	☐	☐
14. Paralysis, epilepsy, multiple sclerosis or other neuromuscular disorder?	☐	☐
15. Bleeding or blood disorders, (except for HIV infection)?	☐	☐

Other Conditions/Information

16. Are you or any dependents now pregnant?	☐	☐
17. Any other medical condition that has not been disclosed above? If so, describe in detail below.	☐	☐
18. Have you or your dependents smoked in the last 2 years? If Yes, date stopped - _____	☐	☐
19. Are you or any of your dependents taking any medication (except contraceptives) that require a prescription by a physician?	☐	☐
20. Have you or your dependents gained or lost more than 20 pounds in the last year? □ Gained _____ □ Lost _____	☐	☐

HIV Testing Prohibited: California law prohibits a HIV test from being required or used by a health insurance company or health care service plan as a condition of obtaining health coverage.

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HEALTH STATEMENT (continued)

(Please print)

Employee Name	**Social Security #**

Complete The Following For Any "Yes" Responses From Questions 1 To 20:

(Please indicate the question number above)

Q.#	Dependent (or Self) Name	Name and Address of Physician or Clinic	Date Treatment Began AND Ended	Name of Condition(s) Illness(es) Treated	Indicate Treatment Rendered and Current Status (Recovered, Still in Treatment?). Include Name of Medication (if taken) and Dates Prescribed

Attach additional sheets if necessary.

By signing below, I certify that my answers and statements are true and complete to the best of my knowledge and belief. I understand that this Employee Application, including this Health Statement, is a part of my and my dependents' application to be added to my employer's Blue Shield of California health plan contract or Blue Shield Life Policy. I understand that if I have misrepresented or omitted any material fact that my coverage may be cancelled or my employer's contract rescinded.

Signature of Employee X _____ **Date X** _____